MDR Tracking Number: M5-04-1205-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on December 30, 2003.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the hot/cold pack therapy, therapeutic exercises, neuromuscular re-education, therapeutic activities were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatments listed above were not found to be medically necessary, reimbursement for dates of service from 12-30-02 to 04-02-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 18th day of March 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

March 12, 2004

Re: IRO Case # M5-04-1205

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is Board Certified in Orthopedic Surgery and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

History
The patient is a 48-year-old female who underwent a right shoulder arthroscopy with rotator cuff debridement and acrimioplasty on ___. Prior to surgery she attended six visits with a physical therapist, who performed therapeutic exercises with modalities. She attended postoperative physical therapy from September 2002 through April 2003.

Requested Service(s)
Hot/cold pack ther, ther exer, neuromuscular reed, ther activities 12/30/02-4/2/03

Decision
I agree with the carrier's decision to deny the requested services.

Rationale
The patient underwent an outpatient shoulder arthroscopy with debridement of a partial (25 percent) supraspinatus tear and arthroscopic acromioplasty. The operating surgeon wrote a prescription for physical therapy, and perhaps in error wrote that he performed an open rotator cuff repair. Therefore, the physical therapist believed that that the patient underwent an open rotator cuff repair. The operative report, however, indicates that an arthroscopic procedure was performed. Based on the records provided for review, physical therapy beyond the dates approved, was not medically necessary. At that point after shoulder arthroscopy, the patient should have been well trained in a home exercise program, including rotator cuff strengthening. The documentation provided for this review is inadequate to support supervised physical therapy beyond the dates approved in December.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.